2014-0	2-20 12:49	AND LUMAN OF BUILDING		, >> pt of Health-	HCEP_1/17
CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	45	~ 3 1 (a) <i>[</i> []	RINTED: 02/07/201 FORM APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		445253	B. WING		
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/30/2014
		ABILITATION -LOUDON		1520 GROVE ST BOX 190 LOUDON, TN 37774	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
\$S=D	Based on the complete resident, the facility who displays mental difficulty receives appearated to correct the facility failed to in logs for the months of January 2014 for on reviewed for behavior reviewed in stage two The findings included Resident #77 was accorded to the facility failed to in reviewed in stage two The findings included Resident #77 was accorded to the findings included to the findings included the findings inclu	rehensive assessment of a must ensure that a resident or psychosocial adjustment opropriate treatment and he assessed problem. T is not met as evidenced ecord review and interview, implement behavior monitor of December 2013 and e (#77) of one resident ors of twenty residents to. d: Imitted to the facility on ith diagnoses including Endocertension, Diabetes, attack, Status Post Liver and Agitation. w of the Care Plan dated vealed "monitor for ior hallucinations by visual	F 319	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of corn does not constitute admission or agreement by the provider of the truth of the facts alleged or conclused forth in the statement of deficiencies. The plan correction is prepared and/or executed solely bed it is required by the provisions of federal and state. F 319 It is the practice of this facility to ensure residents who display mental or psychosocial adjustment difficulty receivappropriate treatment and services to conthe assessed problem. Resident #77 expired on January 5, 2014 therefore no corrective action could be completed for behavior monitoring for the month of January 2014 The DNS (Director Nursing Services)/ADNS (Assistant Director Nurservices)/Social Services or designee reviewed all residents in the facility with behavior monitoring plans for appropriate behavior monitoring documentation and none were found to be lacking appropriate documentation. The DNS/ADNS/SDC(Staff Developme Coordinator)/Social Services or designee will review residents on admission, utilizing the admission nursing evaluation and fourteen day behavior monitoring lo determine those residents with behaviors.	e usions m of cause te law. Ves rect 4 02/03/2014 rsing te i te i on og to al
	Review of facility poli dated August 31, 201 behavior monitoring I	cy, Psychoactive Drug Use, 2, revealed "Implement a og or similar mechanisms to		issues. Once the determination has been made and a resident is placed on behavior monitoring, the Interdisciplinary Team (Nursing, Social Services, Dietary, Activities and Rehabilitation department	or
ABORATORY	DIRECTOR'S OR PROVIDE	RYSUPPLIER REPRESENTATIVE'S SIGNA	ATURE	Executare Director	(X6) DATE
Bu dottolono	ata a sa			CARLUTATE VILLECTOR	2/20/2014

iny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

2014-02-20 12:49
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

>> pt of Health HCE P 2/17
PRINTED: 02/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING CC		
		445253	B. WING_		04/04/04	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION -LOUDON			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774	01/30/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTIES OF THE A	BE COMPLETION :	
F 356 SS=C	therapy" Medical record revial Recapitulation Order with order start date revealed "Anti-Psymonitored or modified Record number of Eshift, Document in Management of the conference room on p.m., revealed the fadocument behavior in December 2013 and 483.30(e) POSTED INFORMATION	ew of the Physician's rs dated January 1, 2014, of October 31, 2013, rchotic: Behavior to be ed is Dementia Agitation, pisodes/Occurances Per Medical Record as Needed" rector of Nursing in the January 30, 2014, at 4:15 edility failed to implement and monitoring for the months of January 2014.	F 31	mornings on clinical rounds to ensure behavior monitoring documentation is completed on those residents identified Residents who may develop onset of ne behaviors will have behavior monitorin plans developed by the IDT as indicate Any new plan will be monitored for appropriate documentation during clini rounds Monday through Friday morning the IDT. The SDC will in-service licensed staff appropriate behavior monitoring documentation. Residents on behavior monitoring will be reviewed during Qu Assurance meetings, monthly for three months then quarterly thereafter.	g cal gs by O2/10/2014 ality	
	o The current date. o The total number a by the following cate; unlicensed nursing si resident care per shit - Registered nurs - Licensed practic vocational nurses (as - Certified nurse a o Resident census. The facility must post specified above on a of each shift. Data m o Clear and readable	es. cal nurses or licensed defined under State law). aides. the nurse staffing data daily basis at the beginning ust be posted as follows:		o Current date o Total number and actual hours worked by the following categor of licensed and unlicensed nurs staff directly responsible for resident care per shift: o Registered Nurses o Licensed Practical Nurses o Certified Nurse Aides o Resident census The specified above data will be posted prominent place readily accessible to resident and visitors. The DNS/ADNS/Staffing Coordinator/Mana, on Duty or designee will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Frid The Manager on Duty will post the specific data each morning Monday through Prid The Manager on Duty will pos	on a 01/31/2014 ger ed av.	

DEPAR		AND HUMAN SERVICES			. >> pt of Health	PHCETE	D: 02/07/2014	ļ
	RS FOR MEDICARE T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/V0\ \ 1 # # 700			<u>ОМВ И</u>	M APPROVED O. 0938-0391	
	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTI		(X3) D,	ATE SURVEY OMPLETĘD	
<u>.</u>		445253	8. WING_		·		1/30/2014	
NAME OF PROVIDER OR SUPPLIER					DRESS, CITY, STATE, ZIP CODE		1/30/2014	
KINDRE	D NURSING AND REH	ABILITATION -LOUDON			VE ST 80X 190 , TN 37774			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST 85 PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	; (E	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BF	(X5) COMPLETION DATE	
	make nurse staffing for review at a cost is standard. The facility must may staffing data for a more required by State law. This REQUIREMENT by: Based on observation as required. The findings included as required. The findings included to unit 2 nurse's state information posted dinursing staff on duty. Observation of the posted control of the pos	on oral or written request, data available to the public not to exceed the community intain the posted daily nurse inimum of 18 months, or as v, whichever is greater. T is not met as evidenced on and interview, the facility te nurse staffing information d: ary 27, 2014, at 5:28 a.m., at tion revealed the staffing id not accurately reflect the for the current day, osted nurse staffing revealed on posted was the staff January 24, 2014, and had reflect current nurse staff in	F 356	Staff De service: where a posted. validate Assuran	Saturday and Sunday morning evelopment Coordinator will all Manager on Duty personned when the specified data is Nurse staffing data posting will daily and reviewed in Qualice meeting Monthly for three and then quarterly thereafter.	in- el on to be ill be ity	1/31/14	
	time of the observation confirmed the staffing the current nurse state facility had failed to pe	on on January 27, 2014, Information did not reflect If present and confirmed the lost accurate staffing.		r				
₽ 371 .	483 35(i) EOOD DRO	CLIBE	E 074	F371				

SS=F STORE/PREPARE/SERVE - SANITARY

It is the practice of this facility to procure food from sources approved or considered

satisfactory by Federal, State or local

2014-02-20 12:50 >> pt of Healthank GFED: 826/12014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING __ COMPLETED 445253 B. WING 01/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 KINDRED NURSING AND REHABILITATION -LOUDON LOUDON, TN 37774 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 371 Continued From page 3 authorities; and to store, prepare, distribute F 371 The facility must and serve food under sanitary conditions. (1) Procure food from sources approved or 2/3/14considered satisfactory by Federal, State or local The dietary staff was educated on proper policy and procedure regarding dishwashing authorities; and 2/7/14 (2) Store, prepare, distribute and serve food by the Certified Dietary Manager. under sanitary conditions The dietary aide responsible for dishwashing 1/28/14 will check each dish rack after it is removed from the dishwasher for cleanliness per policy and procedure. The Dietary Manager or designee will 1/31/14 This REQUIREMENT is not met as evidenced monitor all food service implements for bv: cleanliness after each meals dishwashing is Based on observation, review of completed as part of the facility nutritional refrigerator/freezer temperature log, review of service quick rounds. facility policy, and interview, the facility failed to store dishes in a sanitary manner, failed to maintain three of four unit refrigerators in a sanitary manner, and failed to maintain the refrigerator/freezer temperature log for the month of January. The dietary staff was educated on proper The findings included: policy and procedure temperature monitoring by the Certified Dietary Observation in the kitchen on January 28, 2014, Manager. at 11:10 a.m., revealed twelve of fifty-three bowls Dietary Manager or designee will monitor from a total of five clean storage racks contained the dictary staff with daily checks of the dried debris.

clean.

Interview with Dietary Aide #1 on January 28,

Review of the Facility Refrigerator/Freezer

temperatures for January 24, 2014. Further

Temperature log, dated January 2014 revealed failure to log the freezer and the refrigerator

review revealed failure to log temperatures for the freezer and the refrigerator in the a.m. on January

2014 at 11:15 a.m., confirmed the bowls were not

thereafter.

temperature logs.

The temperature control log will be reviewed

weekly for one month, then bi-weekly for

two months by the Registered Dietician.

After this time it will be reviewed monthly

during the routine kitchen inspection.

The Registered Dietician will present findings monthly at Quality Assurance

monthly for three months then quarterly

2/3/14

2014-02-20 12:50 >> pt of Healths NGTED: 825/12014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 445253 B. WING 01/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 KINDRED NURSING AND REHABILITATION -LOUDON LOUDON, TN 37774 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DAI'E (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 371 Continued From page 4 F 371 25 and 26, 2014. Review of facility policy, Food and Supply Storage, dated August 31, 2012, revealed "...,Refrigerator and freezer temperatures are taken and recorded twice a day (am and pm)..." Interview with Dietary Manager in the kitchen on January 27, 2014, at 6:35 a.m., confirmed the refrigerator and the freezer temperatures on January 24, 2014, and the a.m. temperatures for the freezer and the refrigerator on January 25 and 26, 2014, were not recorded on the temperature log. The DNS/ADNS/Unit Manager or designee Observation and interview with Licensed Practical 02/03/2014

Nurse (LPN) #1, on January 27, 2014, at 5:15 a.m., in the 300 hall clean utility room, revealed the refrigerator used to store resident pudding. snacks, and liquids, had yellow dried liquid on the interior of the door and top shelf. Continued observation revealed an unlabeled, undated bag containing wrapped undated bread items and an unlabeled, undated cool whip container on the middle shelf and an open carton of a thickened juice product, undated on an interior door shelf.

Interview with LPN #I, on January 27, 2014, at 5:15 a.m., in the 300 hall clean utility room, food stored in the refrigerator was to be dated and labeled.

confirmed the refrigerator was not clean and all

will post a schedule for the clean utility room and hospice refrigerators to be checked for labeled and dated food items and for cleanliness of the refrigerators on each nursing unit. A notice placard will be placed on the exterior of the refrigerators to give notice to all staff that all items placed in the refrigerators for residents must be labeled and dated. A placard will also be placed on the exterior of the hospice kitchen refrigerator to inform hospice residents family members that all items placed in the refrigerator must be labeled and dated prior to placing items in the refrigerator. The DNS/ADNS/Unit Manager or designee will monitor the refrigerators Monday through Fridays to validate that items in the refrigerators are dated and labeled and that refrigerators are clean, Manager on Duty will validate on Saturdays and Sundays.

Observation of the refrigerator in the medication ORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 66U611

Pacility ID: TN5303

If continuation sheet Page 5 of 9

2014-02-20 12:51
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

>> pt of Health-HCE P 6/17 PRINTED: 02/07/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1), PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u> </u>		445253	B. WING			
ļ	PROVIDER OR SUPPLIER ED NURSING AND REH	ABILITATION -LOUDON		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774	01/30/2014	
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIORS)	(X5) BE COMPLETION ATE DATE	
F 371	room at Nurse's Sta at 6:15 a.m., reveale Creamy Whip and o full, with a yellowish undated Interview with LPN # 6:20 a.m., in the me Station 2 confirmed Creamy Whip and the	ge 5 Ition two on January 27, 2014, ed one eight ounce carton of one quart bag, three fourth's brown liquid unlabeled and etga on January 27, 2014, at dication room at Nurse's the eight ounce carton of the quart bag three fourth's full quid was unlabeled and	F 37	The Staff Development Coordinator will service the nursing department staff on appropriate food labeling and storing, as well as recognizing when cleaning of the interior of the refrigerator is necessary. The DNS/ADNS/SDC or designee will report the results of the daily monitoring the Quality Assurance meeting		
F 441 SS=D	revealed the refrigeraliter bottles of soda a sauce, unlabeled and interview with LPN # 5:50 a.m., confirmed refrigerator were for and undated, and sha and dated. 483.65 INFECTION (SPREAD, LINENS) The facility must esta infection Control Prografe, sanitary and control help prevent the definition Control Fig. (a) Infection Control F	3 on January 27, 2014, at the contents of the resident use, were unlabeled build have had been labeled CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.	F 441	F441 It is the practice of this facility to establis and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help previble development and transmission of dise and infection. The Staff Development Coordinator has is serviced licensed nurses on the appropriate cleaning procedure for glucometers using Sani-cloth wipes. Licensed Practical Nurse #1 has received	n- 1/28/14 te the	

2014-02-20 12:51
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

>> pt of Health PRINTED: P02707/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		445253	B. WING	·		120/2044
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION -LOUDON			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774	<u>i U1</u>	/30/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		LD BE	COMPLETION DATE
F 441	(1) investigates, con in the facility, (2) Decides what proshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable disertions direct contact will train (3) The facility must hands after each direct contact will train washing is indiprofessional practice (c) Linens Personnel must hand	ntrols, and prevents infections recedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. and of Infection ion Control Program esident needs isolation to of infection, the facility must prohibit employees with a case or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which icated by accepted	F4	one on one education by the Staff Development Coordinator on the apy cleaning procedure for the glucomet utilizing Sani-cloth wipe per manufar recommendations. A timer has been on all medication carts to ensure manufactures recommendations are for the specified amount of time, DNS/ADNS/SDC or designee will n by direct observation on an unannou basis to validate that the timer is util ensure manufacturer's recommendat followed for the appropriate cleaning DNS/ADNS/SDC or designee will re monitoring log monthly at Quality Assurance meeting monthly for three then quarterly thereafter.	er cturer's placed followed conitor need ized to ions are g time.	. 1/31/14
	by: Based on observation manufacturer's reconfailed to clean gluconmanufacturer's reconfined include	mmendations.				
		uary 27, 2014, at 7:15 a.m., v revealed Licensed Practical				

2014-02-20 12:51
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

>> pt of Health PROTED: P0207/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445253	B. WING_		01/	30/2014
	PROVIDER OR SUPPLIER D NURSING AND REH	ABILITATION -LOUDON		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774	1 47	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DÉFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE i	(XS) COMPLETION DATE
	Continued observation of procedure was of the glucometer with of procedure was of interview with LPN: 7:15 a.m., regarding after use revealed for thirty seconds to training on how to containing on how to contain a series of Sani-Cloth we exposure time of on 483,70(h) SAFE/FUNCTIONAE ENVIRON The facility must prospect the sanitary, and comforms and comforms and comforms and containing the shower stalls. First procedure of the sanuary 27, 2014, and missing tile on the shower stalls. First procedure with the shower stalls.	aning a glucometer after use. ion revealed LPN #1 wiped a Sani-Cloth wipe. No timing oserved. #1 on January 27, 2014, at g cleaning the glucometerit is wiped with Sani- wipe one minuteI didn't receive lean it" urer's recommendation for ipes for cleaning revealed an e to four minutes. L/SANITARY/COMFORTABL ovide a safe, functional, rtable environment for the public. T is not met as evidenced on and interview, the facility safe and sanitary environment er rooms observed.	F 448		s have ctor. he Unit 2	2/10/14
	floor in the second s	hower stall.		log.	-	

2014-02-20 12:52
DEPARTMENT OF HEALTH AND HUMAN SERVICES

>> pt of HealthpWGFED: P0290712014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445253	B. WING		01/	30/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION -LOUDON			'	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 GROVE ST BOX 190 LOUDON, TN 37774	,		
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F 465	January 27, 2014, at tile on the lower our stall. Interview with the L 2014, at 6:58 a.m., missing tile and the room on Unit 2. Interview with the N January 27, 2014, at 6:58	shower room on Unit 3, on at 7:05 a.m., revealed missing ter corner of the first shower Unit 2 Manager on January 27, confirmed the broken and black residue in the shower Maintenance Supervisor on at 7:05 a.m., confirmed hower room on Unit 3.	F 465				
				ı		,	